REQUEST FOR ADDITIONAL INFORMATION
UT NET AMENDMENT
(DEFINITION & DESCRIPTION OF SERVICES FOR URGENT CARE)

1. “Those clients who have managed care will be transported for urgent care as directed by the plan.” – This implies that each MCO has its own policy about where their enrollees should present for urgent care, probably based on the MCO’s contracted network. Please briefly outline how urgent care transportation for MCO members is arranged - i.e. How is the recipient’s MCO identified? How does the broker/provider identify where each MCO wants its members transported?

2. Please explain the contract provisions for NEMT for the Mental Health capitated contracts which are referenced under the "Excluded Services" of this proposed waiver amendment. How are transportation services provided under the mental health managed care program?

3. Please fully describe the timeline for the following activities:
    - Incorporation of policy change into broker contracts
    - Dissemination of policy change to recipients
    - Implementation of policy change

4. Releases from a Hospital Emergency Room:

    - This paragraph implies that if a recipient goes to the ER using their own or public transportation for which they themselves paid, they may not utilize NET services to return home after that ER visit, unless the visit was deemed to be a true emergency. How will this be operationalized, given the fact that review of the patient’s chart would probably be the only way to determine whether the ER visit was truly an emergency? It is assumed the driver will not be responsible for establishing the existence of an emergency diagnosis prior to transporting the patient back home. If this determination is to be done after-the-fact using claim/encounter data review, is it your intention to try to bill the recipient for the transportation, if the ER visit was determined not to have been an emergency?

    - "True Emergency" is not consistent with the managed care regulations under the Balanced Budget Act (BBA). Please change the phrase and clearly state the "prudent layperson's definition of emergency" as referenced in 42 CFR 438.114 (a).

    - Conversely, this paragraph says that if the transportation was arranged/paid for by the NET program, that the return transport would be covered, even if the ER visit was non-emergent. Doesn’t this defeat your intended purpose of discouraging inappropriate utilization?

5. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the Prepaid Ambulatory Health Plan (PAHP) (i.e. Pick-Me-Up Transportation, Inc.) in the Non-Emergency Medical Transportation Waiver retains 100 percent of the payments. Does the PAHP retain all of the Medicaid capitation payments? Does the entity participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the PAHP is required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

6. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid capitation payment for the PAHP is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

7. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the PAHP.

8. Payments Under Risk Contracts Financial Question. Are there any actual or potential payments to PAHPs, or other providers under this waiver which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.) If so, how do these

arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If managed care contracts include mechanisms such as risk corridors, does the state recoup appropriate amount of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports?

9. 1915(b)(3) financial question. Does any provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?